PRESBYTERIAN
Health Plan, Inc.

Presbyterian Dual Plus (HMO D-SNP)
Formulary Prior Authorization Criteria
Effective January 1, 2027

The formulary may change at any time. You will receive notice when required.

For the most recent list of drugs, information on obtaining a coverage determination or exception, or other resources, visit **www.phs.org/Medicare** or contact our Presbyterian Customer Service Center at:

myPRES app or
phs.org/myPRES

info@phs.org

(505) 923-7675 or
1-855-465-7737
(TTY 711)

October 1 - March 31: 8 a.m. to 8 p.m., seven days a week (except holidays)

April 1 - September 30: 8 a.m. to 8 p.m., Monday - Friday (except holidays)

Learn about Presbyterian's Nondiscrimination Notice and Interpreter Services.

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.

Abilify MyCite (aripiprazole with sensor)

Products Affected

- Abilify MyCite
- Abilify MyCite Maintenance Kit Oral Tablet Therapy Pack 15 MG, 2 MG, 20 MG, 5 MG
- Abilify MyCite Starter Kit Oral Tablet Therapy Pack 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patients with dementia-related psychosis.
Required Medical Information	Chart notes documenting that the patient has tried at least two (2) oral atypical anti-psychotics, one of which must be aripiprazole.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	Reauthorization: Documentation that the patient is clinically stable on Abilify MyCite and the prescriber documents that the patient requires the continued use of Abilify MyCite.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Actiq (fentanyl transmucosal)

Products Affected

- fentaNYL Citrate Buccal Lozenge On A Handle 1200 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Trial and failure of an immediate release oral opiate and must be used in combination with a long-acting oral opiate.
Age Restrictions	16 years or older
Prescriber Restrictions	Oncologist or Pain Specialist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adcirca (tadalafil)

Products Affected

- Alyq
- Tadalafil (PAH)

PA Criteria	Criteria Details
Exclusion Criteria	Tadalafil is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	Documentation of Pulmonary Arterial Hypertension as determined by a right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adempas (riociguat)

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with nitrates, nitric oxide donors, or PDE-5 inhibitors.
Required Medical Information	Diagnosis confirmed by provider in clinical chart Notes
Age Restrictions	18 years or older
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Afinitor (everolimus)

Products Affected

- Everolimus Oral Tablet 10 MG, 2.5 MG, 5 MG, 7.5 MG
- Torpenz

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Afinitor Disperz (everolimus)

Products Affected

- Everolimus Oral Tablet Soluble

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ajovy (fremanezumab)

Products Affected

- Ajovy

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Akeega (niraparib and abiraterone)

Products Affected

- Akeega

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alecensa (alectinib)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alunbrig (brigantinib)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Amjevita (adalimumab-atto)

Products Affected

- Amjevita Subcutaneous Solution Auto-Injector
- Amjevita Subcutaneous Solution Prefilled Syringe 40 MG/0.4ML, 40 MG/0.8ML
- Amjevita-Ped 10kg to <15kg
- Amjevita-Ped 15kg to <30kg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis (RA): Documented diagnosis of Moderate to severe active RA in clinical chart notes. An adequate trial (3 months or more) of one of the following other DMARDs: Hydroxychloroquine, Leflunomide, Methotrexate, Sulfasalazine. Juvenile Idiopathic Arthritis (JIA): Documented diagnosis of Moderate to severe active, polyarticuar JIA in clinical chart notes. An adequate trial (3 months or more) of one of the following DMARDs: Leflunomide, Methotrexate, Sulfasalazine. 2 years or older. Psoriatic Arthritis (PsA): Documented diagnosis of active PsA in clinical chart notes. Ankylosing Spondylitis (AS): Documented diagnosis of active AS. Trial and failure of an NSAID. Crohn's disease (CD): Documented diagnosis of moderately to severely active CD in clinical chart notes as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC in clinical chart notes as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. Plaque Psoriasis (PsO): Documented diagnosis of Moderate to Severe chronic PsO in clinical chart notes. 8. Hidradenitis Suppurativa (HS): Documented diagnosis of moderate to severe Hurley Stage II or III in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	1. RA/JIA/AS - prescribed by or in consultation with a rheumatologist. 2. CD/UC- prescribed by or in consultation with a gastroenterologist. 3. PsO/HS - prescribed by or in consultation with a dermatologist. 4. PsA - prescribed by or in consultation with a dermatologist or rheumatologist. 5. UV prescribed by or in consultation with a ophthalmologist.

PA Criteria	Criteria Details
Coverage Duration	One (1) year
Other Criteria	9. Uveitis: a. Documented diagnosis of non-infectious intermediate, posterior and panuveitis in adult patients and meets the following: i. documented trial failure, contraindication, or intolerance to at least two (2) drugs from the following: conventional therapy such as ophthalmic or systemic corticosteroids AND immunosuppressive drugs (e.g., azathioprine, cyclosporine, methotrexate, or tacrolimus). For all diagnoses: Documented negative tuberculosis test. CONTINUATION CRITERIA: Documentation of beneficial response with treatment
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Androderm (testosterone topical)

Products Affected

- Androderm Transdermal Patch 24 Hour

PA Criteria	Criteria Details
Exclusion Criteria	Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	Trial and failure of Androgel (testosterone gel). Documentation in clinical chart notes of two low total testosterone levels (drawn on separate days) with elevated luteinizing hormone (LH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Androgel 1.62% (testosterone topical)

Products Affected

- Testosterone Transdermal Gel 1.62 %, 10 MG/ACT (2%), 12.5 MG/ACT (1%), 20.25 MG/1.25GM (1.62%), 20.25 MG/ACT (1.62%), 25 MG/2.5GM (1%), 40.5 MG/2.5GM (1.62%), 50 MG/5GM (1%)

PA Criteria	Criteria Details
Exclusion Criteria	Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	Documentation in clinical chart notes of two low total testosterone levels (drawn on separate days) with elevated luteinizing hormone (LH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Apokyn (apomorphine)

Products Affected

- Apokyn Subcutaneous Solution Cartridge
- Apomorphine HCl Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must be used as an adjunct to levodopa and one (1) formulary oral dopamine agonist medication indicated for Parkinson's disease.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Arcalyst (rilonacept)

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	Will not be used in combination with etanercept, adalimumab, anakinra, abatacept, or infliximab.
Required Medical Information	
Age Restrictions	12 years or older for the indications of Cryopyrin-Associated Periodic Syndromes, including Familial Cold Autoinflammatory Syndrome, and Muckle-Wells Syndrome, recurrent pericarditis. Adults and pediatrics weighing 10 kg or more for the maintanence of remission of Deficiency of Interleukin-1 Receptor Antagonist.
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Augtyro (repotrecitinib)

Products Affected

- Augtyro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Austedo (deutetrabenazine)

Products Affected

- Austedo
- Austedo Patient Titration Kit
- Austedo XR
- Austedo XR Patient Titration

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Auvelity (dextromethorphan/bupropion)

Products Affected

- Auvelity Oral Tablet Extended Release 45-105 MG

PA Criteria	Criteria Details
Exclusion Criteria	1. Seizure disorder. 2. Current or prior diagnosis of bulimia or anorexia nervosa. 3. Abrupt discontinuation of alcohol, benzodiazepines, barbiturates, and antiepileptic drugs. 4. Use with an MAOI.
Required Medical Information	1. Member has a clinical diagnosis of major depressive disorder (MDD) as defined by DSM5 criteria or appropriate depression rating scale (e.g., MADRS). 2. Member has had previous treatment , contraindication, or intolerance to at least two antidepressants from two different classes (e.g., SSRI, SNRI). For Agitation Associated with Dementia Due to Alzheimers Disease, documentation that it will not be used as needed (PRN).
Age Restrictions	18 years of age and over
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Avmapki-Fakzynja (avutometinib-defactinib)

Products Affected

- Avmapki Fakzynja Co-Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ayvakit (avapritinib)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Balversa (erdafitinib)

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Benlysta (belimumab)

Products Affected

- Benlysta Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must be used in combination with standard therapy.
Age Restrictions	
Prescriber Restrictions	Nephrologist or Rheumatologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Documentation must be submitted demonstrating a clinical benefit has been established and maintained compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Besremi

Products Affected

- Besremi
- Besremi Pen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Cateogry 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, and some journals.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bosulif (bosutinib)

Products Affected

- Bosulif Oral Capsule
- Bosulif Oral Tablet 100 MG, 500 MG
- Bosutinib Oral Tablet 400 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Braftovi (encorafenib)

Products Affected

- Braftovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bronchitol (mannitol)

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Exclusion Criteria	Failure to pass Bronchitol tolerate test (BTT)
Required Medical Information	1. Diagnosis of cystic fibrosis. 2. Documentation of in adequate response to hypertonic saline and Pulmozyme, unless contraindicated or not tolerated. 3. Documentation that member has successfully complete the Bronchitol tolerance test (BTT).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Brukinsa (Zanubrutinib)

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Buphenyl (sodium phenylbutyrate)

Products Affected

- Sodium Phenylbutyrate Oral Powder 3 GM/TSP
- Sodium Phenylbutyrate Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cabometyx (cabozantinib)

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Calquence (acalabrutinib)

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Caplyta (lumateperone)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, diabetes mellitus, or there is a documented contraindication or intolerance. 2. Bipolar: a. Monotherapy: Trial and failure of two alternatives from the following: lamotrigine, lithium, carbamazepine, valproic acid, Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine). b. adjunct therapy: will be used with either lithium or valproic acid. 3. Major Depressive Disorder (MDD): Major Depressive Disorder (MDD): a. Must be used as adjunctive or add on treatment for MDD, not as monotherapy, AND b. The patient must have a documented trial and failure (minimum of 4 weeks) of at least one (1) drug from the following classes: SSRI, SNRI, bupropion, or mirtazapine, AND c. Trial and failure of aripiprazole or quetiapine in combination with an antidepressant for at least four (4) weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Caprelsa (vandetanib)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Carbaglu (carglumic acid)

Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cayston (aztreonam lysine)

Products Affected

- Cayston

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FEV1 must be 25% to 75% of predicted. Patient must have a positive sputum culture for Pseudomonas aeruginosa.
Age Restrictions	7 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CGRP Inhibitor

Products Affected

- Aimovig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by provider in clinical chart notes
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a Headache Specialist, a Neurologist, Pain Specialist, or Primary Care Provider
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Chlordiazepoxide (high-risk)

Products Affected

- chlordiazePOXIDE HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	No prior authorization if less than 64 years of age or less.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Chlorpromazine (high-risk)

Products Affected

- chlorproMAZINE HCl Oral Tablet 100 MG, 200 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	No prior authorization required if 64 years of age or less.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cibinqo (abrocitinib)

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of refractory, moderate-to-severe atopic dermatitis not adequately controlled with other systemic drug products confirmed by provider in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cinryze (C1 inhibitor-human)

Products Affected

- Cinryze

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Clovique (trientine)

Products Affected

- Trientine HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented intolerance to penicillamine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cobenfy (xanomeline and trospium chloride)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient must have a documented intolerance, side effects or lack of efficacy to at least two (2) other formulary atypical antipsychotics. Medication trials that fail due to lack of efficacy must be attempted for a minimum of 4 weeks if no response, and a minimum of 12 weeks if partial response, unless the patient has a documented intolerance or contraindication to the preferred medication. OR The patient has a current diagnosis of Metabolic Syndrome, Pre-Metabolic Syndrome, or Diabetes Mellitus and has failed ziprasidone or there is clinical documentation why ziprasidone is not clinically appropriate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Colony Stimulating Factor

Products Affected

- Zarxio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by provider in clinical chart notes
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cometriq (cabozantinib)

Products Affected

- Cometriq (100 MG Daily Dose)
- Cometriq (140 MG Daily Dose)
- Cometriq (60 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Copiktra (duvelisib)

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Corlanor (ivabradine)

Products Affected

- Corlanor Oral Solution
- Ivabradine HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Adults: Documented diagnosis of symptomatic chronic heart failure with left ventricular ejection fraction (LVEF) 35% or less, who are in normal sinus rhythm with a resting heart rate of at least 70 beats per minute and are on a beta-blocker or have a contraindication or intolerance to beta-blocker use. Documentation that the patient has tried/failed sacubitril/valsartan or has a contraindication or intolerance to sacubitril/valsartan use. Pediatrics: Documented diagnosis of Symptomatic Heart Failure due to Dilated Cardiomyopathy in patients 6 months of age or older.
Age Restrictions	
Prescriber Restrictions	Cardiologist or in consultation with a Cardiologist or a cardiac care specialist
Coverage Duration	1 year
Other Criteria	Continuation: Documentation of successful response to the medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cosentyx (secukinumab)

Products Affected

- Cosentyx (300 MG Dose)
- Cosentyx Sensoready (300 MG)
- Cosentyx Sensoready Pen
- Cosentyx Subcutaneous
- Cosentyx UnoReady

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Cotellic (cobimetinib)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cresemba (isavuconazonium)

Products Affected

- Cresemba Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following is met: a. the patient has a diagnosis of invasive aspergillosis. b. The patient has a diagnosis of invasive mucormycosis. c. The use of the requested drug is for an indication other than those noted above that is supported by CMS-approved compendia, such as Micromedex and AHFS-Drug Information.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cystaran (cysteamine) ophthalmic solution

Products Affected

- Cystaran

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystinosis diagnosis confirmed by provider in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist
Coverage Duration	6 months
Other Criteria	Reauthorization: documentation of beneficial response to drug therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Danziten (nilotinib)

Products Affected

- Danziten

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daraprim (pyrimethamine)

Products Affected

- Pyrimethamine Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Toxoplasmosis: documentation that the patient will be using a sulfonamide. Toxoplasmosis prophylaxis.
Age Restrictions	
Prescriber Restrictions	Infectious Disease or in consultation with Infectious Disease
Coverage Duration	8 weeks
Other Criteria	Pyrimethamine is not recommended for the treatment of acute malarial attacks and is not included in the CDC recommendations for the treatment of malaria. Pyrimethamine is not the drug of choice for malaria prophylaxis.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daurismo (glasdegib)

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Deferasirox (Jadenu and Exjade)

Products Affected

- Deferasirox Oral Tablet
- Deferasirox Oral Tablet Soluble

PA Criteria	Criteria Details
Exclusion Criteria	eGFR less than 40 ml/min/1.73, patients with poor performance status, patients with high-risk myelodysplastic syndrome (MDS), and patients with advanced malignancies.
Required Medical Information	1. Chronic iron overload due to blood transfusions: The member has received a transfusion of at least 100 mL/kg of packed red blood cells (e.g., at least 20 units of packed red blodd celss for a 40 kg person or more than 20 units in an individual weighing more than 40 kg), and serum ferritin is consistently greater than 1,000 mcg/L. 2. Iron overload in non-transfusion-dependent thalassemia syndromes (NTDT): The member has a liver iron concentration (LIC) of at least 5 mg Fe/g of dry weight and a serum ferritin greater than 300 mcg/L. Baseline lab values required for both indications: renal function, serum transaminases and biliribun, and auditory and ophthalmic examinations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 year
Other Criteria	Continuation criteria: 1. Chronic iron overload due to blood transfusions: routine (monthly) blood counts, liver function, renal function, and ferritin. 2. NTDT: LIC every 6 months, routine (monthly) blood counts, liver function, renal function, and ferritin.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Depen (penicillamine tablets)

Products Affected

- penicillAMINE Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystinuria: Documented trial and failure or intolerance to Thiola (tiopronin).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Renewal: Documentation must be submitted demonstrating a successful response to the medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Drizalma (duloxetine)

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting a trial of, intolerance, or contraindication to duloxetine (Cymbalta) capsule or amitriptyline use in the last 180 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Duloxetine

Products Affected

- DULoxetine HCl Oral Capsule Delayed Release Particles 80 MG, 90 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Titration has been completed with duloxetine 20mg, 30mg, or 60mg
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dupixent

Products Affected

- Dupixent

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Atopic Dermatitis (AD): Documented diagnosis of moderate to severe atopic dermatitis in clinical Chart Notes. AD not adequately controlled. 2. Asthma: Documented diagnosis of Eosinophilic phenotype or oral corticosteroid dependent moderate to severe asthma in clinical chart notes. Used as add on maintenance treatment of adult and pediatric patients 6 years and older. 3. Chronic Rhinosinusitis with Nasal Polyps: Documented diagnosis of inadequately controlled Chronic Rhinosinusitis with Nasal Polyps in clinical chart notes. Add on maintenance treatment in adult and pediatric patients 12 years and older. 4. Eosinophilic Esophagitis (EoE): Documented Diagnosis in clinical chart Notes. Treatment of adult and pediatric patients 1 year and older, weighing at least 15 kg. 5. Prurigo Nodularis: Documented Diagnosis in clinical chart Notes 6. Chronic Obstructive Pulmonary Disease (COPD): Documented Diagnosis of eosinophilic phenotype in clinical chart Notes. Add on maintenance treatment of adult patients with inadequately controlled COPD.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months, Continuation: 1 year
Other Criteria	7. Chronic Spontaneous Urticaria (CSU): Documentation of diagnosis in adult or pediatric patients 2 years and older with CSU who remain symptomatic despite H1 antihistamine treatment. 8. Bullous Pemphigoid: Documented diagnosis in clinical chart notes. 9. Allergic Fungal Rhinosinusitis (AFRS): Documentation of diagnosis in adult or pediatric

PA Criteria	Criteria Details
	patients aged 6 years and older with AFRS. Continuation: Documented beneficial response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Emend (aprepitant oral)

Products Affected

- Aprepitant
- Emend Oral Suspension Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Emgality (galcanezumab-gnlm)

Products Affected

- Emgality

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Enbrel (etanercept)

Products Affected

- Enbrel Mini
- Enbrel Subcutaneous Solution 25 MG/0.5ML
- Enbrel Subcutaneous Solution Prefilled Syringe
- Enbrel Subcutaneous Solution Reconstituted
- Enbrel SureClick Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Rheumatoid Arthritis (RA): Documented diagnosis of Moderate to severe active RA in clinical chart notes. An adequate trial (3 months or more) of one of the following other DMARDs: Hydroxychloroquine, Leflunomide, Methotrexate, Sulfasalazine 2. Juvenile Idiopathic Arthritis (JIA): Documented diagnosis of Moderate to severe active, polyarticuar JIA in clinical chart notes. An adequate trial (3 months or more) of one of the following DMARDs: Leflunomide, Methotrexate, Sulfasalazine. 2 years or older. 3. Psoriatic Arthritis (PsA): Documented diagnosis of active PsA in clinical chart notes. 4. Ankylosing Spondylitis (AS): Documented diagnosis of active AS. : Trial and failure of an NSAID. 5. Plaque Psoriasis (PsO): Documented diagnosis of Moderate to Severe chronic PsO in clinical chart notes. 4 years or older. 6. Juvenile Psoriatic Arthritis (JPsA): Documented diagnosis of active JPsA in clinical chart notes. 2 years or older.
Age Restrictions	
Prescriber Restrictions	1. AS/JIA/RA - prescribed by or in consultation with a rheumatologist. 2. PsA- prescribed by or in consultation with a dermatologist or rheumatologist 3. PsO- prescribed by or in consultation with a dermatologist.
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For all diagnoses: Documented negative tuberculosis test CONTINUATION CRITERIA: Documentation of beneficial response with treatment
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Endari (L-glutamine)

Products Affected

- L-Glutamine Oral Packet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of sickle cell disease. 2. Will be used to reduce acute complications of sickle cell disease. 3. Will be used concurrently with hydroxyurea, unless contraindicated or not tolerated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation therapy: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ensacove (ensartinib)

Products Affected

- Ensacove

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Entocort (budesonide capsules)

Products Affected

- Budesonide Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. The member has a diagnosis of mild to moderate Crohn's disease. 2. Documented trial and failure of sulfasalazine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Entyvio (vendolizumab)

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Ulcerative Colitis (UC): Documented diagnosis of Moderate to Severe UC. The member has had an inadequate response to one TNF blocker (infliximab and adalimumab) and ustekinumab 2. Crohns (CD): Documented diagnosis of Moderate to Severe CD. The member has had an inadequate response to one TNF blocker (infliximab and adalimumab) and ustekinumab.
Age Restrictions	18 years of age or older
Prescriber Restrictions	gastroenterologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation Criteria: Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Epclusa (sofosbuvir/velpatasvir)

Products Affected

- Sofosbuvir-Velpatasvir

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records documenting the diagnosis of chronic Hepatitis C genotype 1,2,3,4,5, or 6.
Age Restrictions	3 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a infectious disease specialist, hepatologist, or gastroenterologist.
Coverage Duration	Duration as per package insert or Class I or II recommendation by the AASLD/IDSA/IAS-USA guidelines
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Epidiolex (cannabiddiol)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Lennox-Gastaut Syndrome: Diagnosis of Lennox-Gastaut Syndrome and seizures have been inadequately controlled by a trial of at least two antiepileptic drugs (e.g. clobazam, valproate, lamotrigine, topiramate, levetiracetam). Dravet Syndrome: Diagnosis of Dravet Syndrome and seizures have been inadequately controlled by a trial of at least two antiepileptic drugs (e.g. clobazam, valproate, lamotrigine, topiramate, levetiracetam).
Age Restrictions	1 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a Neurologist
Coverage Duration	Initial: 6 months Reauthorization: 1 year
Other Criteria	AST, ALT and total bilirubin levels will be obtained 1 month, 3 months, and 6 months after initiation, then periodically thereafter or as clinically indicated.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Erivedge (vismodegib)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erleada (apalutamide)

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erythropoietin Stimulating Agents

Products Affected

- Retacrit Injection Solution 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Esbriet (pirfenidone)

Products Affected

- Pirfenidone Oral Capsule
- Pirfenidone Oral Tablet 267 MG, 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis confirmed by high-resolution computed tomography (HRCT). 2. Exclusion of other known causes, such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity. 3. Baseline Forced Vital Capacity (FVC)
Age Restrictions	18 years or older
Prescriber Restrictions	Pulmonologist
Coverage Duration	1 year
Other Criteria	Baseline Liver Function test
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fanapt (iloperidone)

Products Affected

- Fanapt
- Fanapt Titration Pack
- Fanapt Titration Pack A
- Fanapt Titration Pack B Oral Tablet
- Fanapt Titration Pack C Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, diabetes mellitus, or a documented contraindication or intolerance. 2. Bipolar: a. Monotherapy: Trial and failure of two alternatives from the following: lamotrigine, lithium, carbamazepine, valproic acid, Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine). b. adjunct therapy: will be used with either lithium or valproic acid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Farydak (panobinostat)

Products Affected

- Farydak

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fasenra (benralizumab)

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis in clinical chart notes of severe asthma (eosinophilic phenotype), in adult and pediatric patients age 6 years and older. Requested as maintenance add-on therapy, not monotherapy. Eosinophilic Granulomatosis with polyangiitis (EGPA): Documented diagnosis of EGPA in clinical chart notes. Hypereosinophilic Syndrome (HES): Documented diagnosis of HES in adult and pediatric patients 12 years and older without an identifiable non-hematologic secondary cause.
Age Restrictions	
Prescriber Restrictions	Allergist, Pulmonologist, Dermatologist, Rheumatologist, Immunologist, or hematologist
Coverage Duration	Initial: 9 months Continuation: 12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fensolvi (leuprolide)

Products Affected

- Fensolvi
- Fensolvi (6 Month)

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for treatment of prostate cancer
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ferriprox (deferiprone)

Products Affected

- Deferiprone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an absolute neutrophil count (ANC) greater than 1.5x10^9/L before starting therapy. Patient must have tried and failed or have a contraindication to deferasirox. ANC levels are not required for iron tranfusional overload in patients with sickle cell disease or other anemias.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For renewal, Documentation of decreased ferritin levels
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Filspari (sparsentan)

Products Affected

- Filspari

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Primary immunoglobulin A nephropathy(IgAN): Documented diagnosis in clinical chart notes. To slow kidney function decline in adults with IgAN who are at risk for disease progression. Focal segmental glomerulosclerosis (FSGS): Documented diagnosis in clinical chart notes. To reduce proteinuria in adult and pediatric patients 8 years and older with (FSGS) without nephrotic syndrome. Both the patient and the physician must be enrolled in the mandatory Filspari REMS with baseline LFTs.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a nephrologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation Criteria: Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Firazyr (icatibant)

Products Affected

- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Firdapse (amifampridine)

Products Affected

- Firdapse

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS), documentation of baseline confirmatory diagnostic test results including but not limited to: a Repetitive Nerve Stimulation (RNS), a positive anti-P/Q type voltage-gated calcium channel antibody test, a Quantitative Myasthenia Gravis (QMG) score, a triple-timed up-and-go test (3TUG), a Timed 25-foot walk test (T25FW).
Age Restrictions	6 years of age and older
Prescriber Restrictions	Neurologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fotivda (Tivozanib)

Products Affected

- Fotivda

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fruzaqla (fruquintinib)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gamunex-C (human immune globulin)

Products Affected

- Flebogamma DIF
- Gamunex-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gattex (teduglutide)

Products Affected

- Gattex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of short-bowel syndrome who require parenteral nutrition.
Age Restrictions	1 year of age and older
Prescriber Restrictions	Gastroenterologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gavreto (pralsetinib)

Products Affected

- Gavreto

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gilotrif (afatinib)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gleevec (imatanib)

Products Affected

- Imatinib Mesylate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLP-1 Agonists

Products Affected

- Mounjaro Subcutaneous Solution Pen-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Type 2 Diabetes Mellitus (T2DM).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 Months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gomekli (mirdametinib)

Products Affected

- Gomekli

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hadlima (adalimumab-bwwd)

Products Affected

- Hadlima
- Hadlima PushTouch

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Rheumatoid Arthritis (RA): Documented diagnosis of Moderate to severe active RA in clinical chart notes. An adequate trial (3 months or more) of one of the following other DMARDs: Hydroxychloroquine, Leflunomide, Methotrexate, Sulfasalazine 2. Juvenile Idiopathic Arthritis (JIA): Documented diagnosis of Moderate to severe active, polyarticuar JIA in clinical chart notes. An adequate trial (3 months or more) of one of the following DMARDs: Leflunomide, Methotrexate, Sulfasalazine. 2 years or older. 3. Psoriatic Arthritis (PsA): Documented diagnosis of active PsA in clinical chart notes. 4. Ankylosing Spondylitis (AS): Documented diagnosis of active AS. : Trial and failure of an NSAID. 5. Crohn's disease (CD): Documented diagnosis of moderately to severely active CD in clinical chart notes as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. 6. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC in clinical chart notes as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. 7. Plaque Psoriasis (PsO): Documented diagnosis of Moderate to Severe chronic PsO in clinical chart notes. 8. Hidradenitis Suppurativa (HS): Documented diagnosis of moderate to severe Hurley Stage II or III in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	1. RA/JIA/AS - prescribed by or in consultation with a rheumatologist. 2. CD/UC- prescribed by or in consultation with a gastroenterologist. 3. PsO/HS - prescribed by or in consultation with a dermatologist. 4. PsA - prescribed by or in consultation with a dermatologist or rheumatologist. 5. UV prescribed by or in consultation with a ophthalmologist.
Coverage Duration	One (1) year

PA Criteria	Criteria Details
Other Criteria	9. Uveitis: a. Documented diagnosis of non-infectious intermediate, posterior and panuveitis in adult patients and meets the following: i. documented trial failure, contraindication, or intolerance to at least two (2) drugs from the following: conventional therapy such as ophthalmic or systemic corticosteroids AND immunosuppressive drugs (e.g., azathioprine, cyclosporine, methotrexate, or tacrolimus). For all diagnoses: Documented negative tuberculosis test. CONTINUATION CRITERIA: Documentation of beneficial response with treatment
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Hernexeos (zongertinib)

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hetlioz (tasimelteon)

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have a documented diagnosis of (1) Non-24-Hour Sleep-Wake Disorder in adults or (2) Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older.
Age Restrictions	
Prescriber Restrictions	Sleep Specialist or Neurologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	For renewal, chart notes must show clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hexalen (altretamine)

Products Affected

- Hexalen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

High Risk Medication - Paroxetine

Products Affected

- PARoxetine HCl
- Paxil Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	You must have taken two (2) of the following drugs: a selective serotonin reuptake inhibitor (SSRI) or a serotonin norepinephrine reuptake inhibitor (SNRI).
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

High Risk Medications (estrogen containing products)

Products Affected

- Alora
- Amabelz
- Estropipate Oral
- Jevantique Lo
- Jinteli Oral Tablet 1-5 MG-MCG
- Lopreeza
- Menest
- Mimvey Lo
- Norethindrone-Eth Estradiol Oral Tablet 0.5-2.5 MG-MCG
- Premphase
- Prempro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hydroxyzine HCl and Pamoate

Products Affected

- hydrOXYzine HCl Oral Tablet
- hydrOXYzine Pamoate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Anxiety: Chart notes documenting at least two medications tried and failed for anxiety (e.g., buspirone, citalopram, fluoxetine, sertraline, duloxetine, venlafaxine). Pruritis: Chart notes documenting at least one medication used for itching (e.g. oral antihistamine, topical steroid).
Age Restrictions	No Prior Authorization is required if 64 years of age or less.
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Hyrnuo (sevabertinib)

Products Affected

- Hyrnuo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ibrance (palbociclib)

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ibtrozi (taletrectinib)

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iclusig (ponatinib)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Idhifa (enasidenib)

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Documentation of an isocitrate dehydrogenase-2 (IDH2) mutation detected by an FDA-approved test.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imbruvica (ibrutinib)

Products Affected

- Imbruvica Oral Capsule
- Imbruvica Oral Suspension
- Imbruvica Oral Tablet 140 MG, 280 MG, 420 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imkeldi (imatinib)

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Increlex (mecasermin)

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Inlyta (axitinib)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inqovi (cedazuridine/decitabine)

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inrebic (fedratinib)

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iressa (gefitinib)

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Itovebi (inavolisib)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ivermectin (s)

Products Affected

- Ivermectin Oral Tablet 3 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite Strongyloides stercoralis OR both of the following: member received the drug within the past 120 days. Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus OR both of the following: member received the drug within the past 120 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iwilfin (eflornithine)

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jakafi (ruxolitinib)

Products Affected

- Jakafi
- Jakafi XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jaypirca (pirtobrutinib)

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jideytro (zidesamtinib)

Products Affected

- Jideytro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Juxtapid (lomitapide)

Products Affected

- Juxtapid Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of homozygous familial hypercholesterolemia in clinical chart notes. Used as adjunct to reduce LDL-C in adult and pediatric patients 2 years and older.
Age Restrictions	2 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Jynarque (tolvaptan)

Products Affected

- Tolvaptan Oral Tablet 30 MG
- Tolvaptan Oral Tablet Therapy Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. Must be 18 years of age or older. b. Diagnosis of ADPKD. c. Positive genetic test for ADPKD (mutation in PKD1 or PKD2 gene), OR i. In members aged 18 to less than 40 years with a first degree relative with ADPKD: greater than or equal to 3 cysts (unilateral or bilateral) using any radiologic method. ii. In members aged 40 to less than 60 years with a first degree relative with ADPKD: greater than or equal to 2 cysts per kidney using any radiologic method. iii. In members aged 60 or older with a first degree relative with ADPKD: greater than or equal to 4 cysts per kidney using any radiologic method. d. Must have CKD stage 2 through 4. eGFR is great than or equal to 25 mL/min/1.73 m2.
Age Restrictions	
Prescriber Restrictions	Prescribed by a nephrologist, endocrinologist, or cardiologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: Documented beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kalydeco (ivacaftor)

Products Affected

- Kalydeco Oral Packet 25 MG, 50 MG, 75 MG
- Kalydeco Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 month old to 5 years of age: Oral granules. 6 years of age or older: Oral tablets.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kerendia (finerenone)

Products Affected

- Kerendia Oral Tablet 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis in clinical chart notes of Chronic Kidney Disease associated with diabetes or Heart failure with preserved ejection fraction.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: Documentation of beneficial response to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Kineret (anakinra)

Products Affected

- Kineret Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Will not be approved for use in combination with TNF antagonists.
Required Medical Information	Documented diagnosis of moderate to severe active rheumatoid arthritis (RA). An adequate trial (3 months or more) of one of the following DMARDs: hydroxychloroquine, leflunomide, methotrexate, sulfasalazine. Trial and failure of one of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, tofacitinib. 2. Neonatal-Onset Multisystem Inflammatory Disease (NOMID): Confirmed diagnosis of NOMID in clinical chart notes. 3. Adult Onset Stills Disease: Confirmed diagnosis in clinical chart notes. 4. Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Confirmed diagnosis of DIRA in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Continuation criteria: Documentation of beneficial response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Kisqali (ribociclib)

Products Affected

- Kisqali (200 MG Dose)
- Kisqali (400 MG Dose)
- Kisqali (600 MG Dose)
- Kisqali 200 Dose
- Kisqali 400 Dose
- Kisqali 600 Dose
- Kisqali Femara (200 MG Dose)
- Kisqali Femara (400 MG Dose)
- Kisqali Femara (600 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Komzifti (ziftomenib)

Products Affected

- Komzifti

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Korlym (mifepristone)

Products Affected

- miFEPRIStone Oral Tablet 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Koselugo (selumetinib)

Products Affected

- Koselugo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Krazati (adagrasib)

Products Affected

- Krazati

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kuvan (sapropterin)

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Authorizations: Medical records documenting all of the following: the target Phe blood level for the patient and dose does not exceed FDA approved maximum for the diagnosis. Renewal: Recent Phe level is at target range.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial authorization: 2 months Renewal: 6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lazcluze (lazertinib)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lenvima (lenvatinib)

Products Affected

- Lenvima (10 MG Daily Dose)
- Lenvima (12 MG Daily Dose)
- Lenvima (14 MG Daily Dose)
- Lenvima (18 MG Daily Dose)
- Lenvima (20 MG Daily Dose)
- Lenvima (24 MG Daily Dose)
- Lenvima (4 MG Daily Dose)
- Lenvima (8 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Leqembi (lecanemab-irmb)

Products Affected

- Leqembi Iqlik
- Leqembi Iqlik (500 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Letairis (ambrisentan)

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, Idiopathic Pulmonary Fibrosis
Required Medical Information	Confirmed diagnosis of primary or secondary pulmonary arterial hypertension (WHO Group 1) by right heart catherization. Is being used to improve exercise ability and delay clinical worsening or in combination with tadalafil to reduce the risks of disease progression and hospitalization for worsening PAH, and to improve exercise ability.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	Continuation criteria: Documentation of beneficial response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Leukine (sargramostim)

Products Affected

- Leukine Injection Solution Reconstituted
- Leukine Intravenous

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with pegfilgrastim or filgrastim.
Required Medical Information	Documented Neutropenia confirmed by provider in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lidoderm (lidocaine topical patch)

Products Affected

- Lidocaine External Patch 5 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lifyorli (relacorilant)

Products Affected

- Lifyorli (125 MG DOSE)
- Lifyorli (150 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Livtencity (maribavir

Products Affected

- Livtencity

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of cytomegalovirus (CMV). For treatment of adults and pediatric patients (12 years and older and weighing at least 35 kg) with post transplant CMV infection, that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Eight (8) Weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lonsurf (tipiracil/trifluridine)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lorbrena (lorlatinib)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lotronex (alosetron)

Products Affected

- Alosetron HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of severe diarrhea-predominant irritable bowel sdrome (IBS) with symptoms persisting for at least six (6) months. 2. Patient was female at birth. 3. Patient has not responsded adequately to conventional therapy (i.e., lopermaide, antispasmodics).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lumakras (sotorasib)

Products Affected

- Lumakras

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lybalvi

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Exclusion Criteria	Know opioid use disorder or is dependent on opioids for a chronic health condition. Patients undergoing acute opioid withdrawal.
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, diabetes mellitus, or there is a documented contraindication or intolerance. 2. Bipolar: a. Monotherapy: Trial and failure of two alternatives from the following: lamotrigine, lithium, carbamazepine, valproic acid, Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine). b. adjunct therapy: will be used with either lithium or valproic acid.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Patient does not have a known opioid use disorder or is dependent on opioids for a chronic health condition. There should be a 7-day opioid-free interval from the last use of short-acting opioids, and at least a 14-day opioid-free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Lynparza (olaparib)

Products Affected

- Lynparza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lytgobi (futibatinib)

Products Affected

- Lytgobi (12 MG Daily Dose)
- Lytgobi (16 MG Daily Dose)
- Lytgobi (20 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Marinol (dronabinol)

Products Affected

- Dronabinol Oral Capsule

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If using for nausea and vomiting associated with cancer chemotherapy, the patient must be receiving cancer chemotherapy and has failed one 5-HT3 antagonist and one of the following: corticosteroid, anti-histamine, anti-psychotic, or prokinetic. If using for anorexia associated with weight loss due to HIV/AIDS, the patient must have a trial and failure, contraindication or intolerance to Megace ES (megestrol oral suspension).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Matulane (procarbazine)

Products Affected

- Matulane

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mavyret (glecaprevir/pibrentasvir)

Products Affected

- Mavyret

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute or chronic Hepatitis C including the genotype in clinical chart notes. Documentation of treatment history if previously treated.
Age Restrictions	3 year of age and older.
Prescriber Restrictions	Gastroenterologist or Infectious Disease specialist or Hepatologist
Coverage Duration	Duration as per package insert or Class I or II recommendation by the AASLD/IDSA/IAS-USA guidelines
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mekinist (trametinib)

Products Affected

- Mekinist

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEKTOVI (binimetinib)

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Modeyso (dordavipron)

Products Affected

- Modeyso

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mounjaro (tirzepatide)

Products Affected

- Mounjaro Subcutaneous Solution Auto-Injector 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Movantik (naloxegol)

Products Affected

- Movantik

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting a trial/failure of lactulose oral or lubiprostone.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Muscle Relaxants

Products Affected

- Cyclobenzaprine HCl Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prior authorization required for patients 65 years of age and older.
Age Restrictions	Prior authorization required for patients 65 years of age and older.
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Natpara (parathyroid hormone)

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records must document a diagnosis of hypocalcemia due to chronic hypoparathyroidism. The prescriber must provide documentation that the patient must has a normal 25-hydroxyvitamin D level and a serum calcium level above 7.5mg/dL. For renewal the albumin-corrected total serum calcium level between 7.5 mg/dL and 10.6 mg/dL should be achieved with standard of care.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nerlynx (neratinib)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Lab values for total bilirubin, AST, ALT, and alkaline phosphate levels prior to starting treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nexavar (sorafenib)

Products Affected

- SORAfenib Tosylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ninlaro (ixazomib)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Northera (droxidopa)

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	2 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Noxafil (posaconazole)

Products Affected

- Posaconazole Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age and older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nubeqa (darolutamide)

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nucala

Products Affected

- Nucala Subcutaneous Solution Auto-Injector
- Nucala Subcutaneous Solution Prefilled Syringe 100 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Maintenance treatment of Severe asthma: Documented diagnosis in clinical chart notes. Add-on maintenance treatment of eosinophilic phenotype severe asthma. Maintenance treatment of Rhinosinusitis with Nasal Polyps: Documented diagnosis in clinical chart notes. Add-on maintenance treatment in adults with inadequate response to nasal corticosteroids. Maintenance treatment of Chronic Obstructive Pulmonary Disease (COPD): Documented diagnosis in clinical chart notes. Maintenance treatment of adult patients with inadequately controlled eosinophilic phenotype COPD. Eosinophilic Granulomatosis with Polyangiitis: documented diagnosis in clinical chart notes. Hypereosinophilic Syndrome (HES): Documented diagnosis in clinical chart notes. HES for greater than or equal to 6 months without an identifiable non-hematologic secondary cause.
Age Restrictions	Asthma 6 years of age or older, Hypereosinophilic Syndrome 12 years of age or older, all other indications 18 years of age or older
Prescriber Restrictions	Allergist, Pulmonologist, immunologist, rheumatologist, hematologist, and otolaryngologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: Documentation of beneficial response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Nuedexta (dextromethorphan-quinidine)

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	Prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, and in patients with heart failure
Required Medical Information	1. Diagnosis of pseudobulbar affect. 2. One of the following: a. Amyotrophic lateral sclerosis (ALS). b. Alzheimer's disease. c. Multiple sclerosis (MS). d. Parkinson's disease. e. Stroke. f. Traumatic brain injury.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nuplazid (pimavanserin)

Products Affected

- Nuplazid Oral Capsule
- Nuplazid Oral Tablet 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nuvigil (armodafinil)

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If using for obstructive sleep apnea (OSA), must provide documentation that the patient has OSA and has been evaluated by a sleep specialist or a lung specialist.
Age Restrictions	
Prescriber Restrictions	Neurologist, Sleep Specialist, pulmonologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Odomzo (sonidegib)

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ofev (nintedanib)

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Idiopathic Pulmonary Fibrosis: Exclusion of other known causes (such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity). Documentation of Baseline pulmonary function tests. 2. Systemic Sclerosis-associated Interstitial Lung Disease: Documentation of Baseline pulmonary function tests. 3. Chronic Fibrosis Interstitial Lung Disease: Progressive phenotype (e.g., hypersensitivity pneumonitis, autoimmune interstitial lung disease, idiopathic nonspecific interstitial pneumonia). For all diagnoses: Documentation of High-resolution computed tomography in clinical Chart Notes to confirm the disease.
Age Restrictions	18 years or older
Prescriber Restrictions	Pulmonologist or rheumatologist
Coverage Duration	1 year
Other Criteria	Baseline Liver Function tests
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ogsiveo (nirogacestat)

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6 months)
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojemda (tovorafenib)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojjaara (momelotinib)

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Omnitrope (somatropin)

Products Affected

- Omnitrope

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Onureg (Azacitidine)

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Opsumit (macitentan)

Products Affected

- Macitentan

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Orencia (abatacept SubQ)

Products Affected

- Orencia ClickJect
- Orencia Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis (RA): Documented diagnosis of Moderate to severe active RA. Inadequate response to two of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, tofacitinib. Psoriatic Arthritis (PsA): Documented diagnosis of active PsA. The patient has had an Inadequate response to two of the following: Amjevita, Enbrel, Hadlima, tofacitinib, Otezla. Polyarticular Juvenile Idiopathic Arthritis (PJIA): Documented diagnosis of active PJIA in clinical chart notes. Inadequate response to two of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, tofacitinib, Tyenne. Prophylaxis for Acute Graft versus Host Disease (aGVHD): Documented diagnosis of aGVHD, in combination with a calcineurin inhibitor and methotrexate. Undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor.
Age Restrictions	RA: 18 years or older, PJIA/PsA: 2 years or older, aGVHD: 2 years of age or older
Prescriber Restrictions	1. RA/JIA - Prescribed by or in consultation with a rheumatologist. 2. PsA - prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Orfadin (nitisinone)

Products Affected

- Nitisinone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orgovyx (Relugolix)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orkambi (ivacaftor/lumacaftor)

Products Affected

- Orkambi Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 year and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orphenadrine (high-risk)

Products Affected

- Orphenadrine Citrate ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	No prior authorization required if 64 years of age or less.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orserdu (elacestrant)

Products Affected

- Orserdu

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Otezla (apremilast)

Products Affected

- Otezla
- Otezla XR
- Otezla/Otezla XR Initiation Pk

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Oxybutynin (high-risk)

Products Affected

- Oxybutynin Chloride Oral Syrup

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	No prior authorization if 64 years of age or less.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ozempic (semaglutide)

Products Affected

- Ozempic
- Ozempic (0.25 or 0.5 MG/DOSE) Subcutaneous Solution Pen-Injector 2 MG/3ML
- Ozempic (1 MG/DOSE) Subcutaneous Solution Pen-Injector 4 MG/3ML
- Ozempic (2 MG/DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Parathyroid Hormone Analogs

Products Affected

- Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML, 620 MCG/2.48ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of one of the following in clinical chart notes: Postmenopausal women with osteoporosis at high risk for fracture or who have failed or are intolerant to other available osteoporosis therapy. To increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture or who have failed or are intolerant to other available osteoporosis therapy. Osteoporosis in men and women associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) at high risk for fracture or who have failed or are intolerant to other available osteoporosis therapy. History of failure, contraindication, or intolerance to an intravenous bisphosphonate AND Wyost, OR Jubbonti.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year.
Other Criteria	Use of Teriparatide injection for more than 2 years during a patients lifetime should only be considered if a patient remains at or has returned to having a high risk for fracture
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Pemazyre (pemigatinib)

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Phyrago (dasatinib)

Products Affected

- Phyrago

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Piqray (alpelisib)

Products Affected

- Piqray (200 MG Daily Dose)
- Piqray (250 MG Daily Dose)
- Piqray (300 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pomalyst (pomalidomide)

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Prevymis

Products Affected

- Prevymis Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Allogenic hematopoietic stem cell transplant: a. patient is CMV-seropositive. b. Prevymis is being prescribed as prophylaxis and not treatment of CMV infection. 2. Kidney transplant: a. patient is CMV-seronegative. b. Donor is CMV-seropositive. c. Prevymis is being prescribed as prophylaxis and not treatment of CMV infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	9 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Prolastin (alpha-1-proteinase inhibitor [human])

Products Affected

- Prolastin-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Promacta (eltrombopag olamine)

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will not be provided when used in combination with Nplate.
Required Medical Information	Persistent or Chronic Immune Thrombocytopenia: Documented diagnosis of thrombocytopenia in adult and pediatric patients 1 year and older with persistent or chronic immune thrombocytopenia (ITP) who have had an insufficient response to corticosteroids and immunoglobulins. Thrombocytopenia in Patients With Hepatitis C Infection: Documented diagnosis of Thrombocytopenia in Patients With Hepatitis C Infection to allow the initiation and maintenance of interferon-based therapy. Severe Aplastic Anemia: Documented diagnosis of Severe Aplastic Anemia in adult and pediatric patients 2 years and older. Used in combination with standard immunosuppressive therapy (IST) . OR, documented Severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pulmonary Arterial Hypertension - ERA

Products Affected

- Bosentan

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Documented confirmed diagnosis of primary or secondary pulmonary arterial hypertension (WHO Group 1) by right heart catherization in clinical chart notes. If the patient is an adult, WHO functional class II-IV symptoms are documented.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Purixan (mercaptopurine)

Products Affected

- Mercaptopurine Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qinlock (ripretinib)

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qualaquin (quinine sulfate)

Products Affected

- QuiNINE Sulfate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rebyota (fecal microbiota, live - jslm)

Products Affected

- Rebyota

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the prevention of the recurrence of Clostridioides Difficile (rCDI) infection in patients who meet all of the criteria: Diagnosis of recurrent Clostridioides Difficile Infection (CDI) as defined by both of the following: Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2consecutive day, and A positive stool test for Clostridioides difficile toxin, and Patient is 18 years of age or older, and Patient has had one or more recurrence(s) of CDI following an initial episode of CDI, and Both of the following: Patient has completed at least 10 days of one of the following antibiotic therapies for rCDI between 24 to 72 hours prior to initiating Rebyota: Oral vancomycin, or Dificid (fidaxomicin) and Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days] and Prescribed by or in consultation with one of the following: Gastroenterologist, Infectious disease specialist.Authorization will be issued for a single dose treatment only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Redemplo (plozasiran)

Products Affected

- Redemplo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of familial chylomicronemia syndrome (FCS). Is being used as adjunct to diet.
Age Restrictions	
Prescriber Restrictions	Cardiologist or Endocrinologist
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Relistor (methylnaltrexone)

Products Affected

- Relistor

PA Criteria	Criteria Details
Exclusion Criteria	Non-opioid induced constipation. Fecal impaction. Acute diverticular disease. Acute surgical abdomen.
Required Medical Information	Documentation that the patient is on chronic opioid therapy, and documented trial and failure of naloxegol (for approval of oral tablets only). Documented trial and failure of naloxegol not required for injection.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Repatha (evolocumab)

Products Affected

- Repatha
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Retevmo (selpercatinib)

Products Affected

- Retevmo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revatio (sildenafil)

Products Affected

- Sildenafil Citrate Oral Tablet 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	Sildenafil is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revcovi (elapegademase-lvlr)

Products Affected

- Revcovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. Diagnosis of adenosine deaminase deficiency (ADA) with Severe Combined Immunodeficiency (SCID) phenotype confirmed by one of the following: i.Absent ADA levels in lysed erythrocytes from fresh blood samples or dried blood spots. ii. Marked increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates (with levels that vary by laboratory). iii. Decrease in ATP concentration in red blood cells. iv. Absent or extremely low levels of S-adenosylhomocysteine hydrolase in red blood cells. v. Increase in 2'-deoxyadenosine in urine and plasma, as well as in dried blood spots vi. Genetic testing showing biallelic variants in the ADA1 gene. b.Patient does not have thrombocytopenia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revlimid (lenalidomide)

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revuforj (revumenib)

Products Affected

- Revuforj

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rexulti (brexpiprazole)

Products Affected

- Rexulti

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Major Depressive Disorder (MDD): Must be used as adjunctive or add on treatment for MDD, not as monotherapy, AND a. The patient must have a documented trial and failure (minimum of 4 weeks) of at least one (1) drug from the following classes: SSRI, SNRI, bupropion, or mirtazapine, AND b. Trial and failure of aripiprazole or quetiapine in combination with an antidepressant for at least four (4) weeks. 2. Schizophrenia: Trial and failure of two (2) atypical antipsychotics for a minimum of four (4) weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, diabetes mellitus, or there is a documented contraindication or intolerance. 3. Documented diagnosis of agitation associated with dementia due to Alzheimer's disease (AD).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Rezdiffra (resmetirom)

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. 18 years or older. b. Diagnosis confirmed with F2/F3 fibrosis. c. Trial and failure, unless contraindicated or not tolerated, Wegovy for the treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH). d. Prescribed by or in consultation with a hepatologist, gastroenterologist or primary care provider.
Age Restrictions	
Prescriber Restrictions	Hepatologist, gastroenterologist, or primary care provider
Coverage Duration	1 year
Other Criteria	Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezlidhia (olutasidenib)

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezurock (belumosudil)

Products Affected

- Rezurock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis of chronic graft-versus-host disease (GVHD). 2. History of failure of at least two prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, tacrolimus, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rinvoq (upadacitinib)

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Romvimza (vimseltinib)

Products Affected

- Romvimza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rozlytrek (entrectinib)

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rubraca (rucaparib)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rybelsus (semaglutide)

Products Affected

- Rybelsus

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of type 2 diabetes mellitus.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rydapt (midostaurin)

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Scemblix

Products Affected

- Scemblix

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Secuado (asenapine transdermal)

Products Affected

- Secuado

PA Criteria	Criteria Details
Exclusion Criteria	Patients with dementia-related psychosis
Required Medical Information	1. Schizophrenia: a. Trial and failure of two (2) atypical antipsychotics for a minimum of 4 weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, diabetes mellitus, or there is a documented contraindication or intolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Signifor (pasireotide)

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a baseline 24-hour urine free cortisol (UFC) greater than 1.5 times the upper limit of normal (ULN).
Age Restrictions	18 years or older
Prescriber Restrictions	Endocrinologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Siklos (hydroxyurea)

Products Affected

- Siklos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sirturo (bedaquiline)

Products Affected

- Sirturo Oral Tablet 100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of multi-drug resistant tuberculosis (MDR-TB).
Age Restrictions	2 years of age weighing at least 8 kg.
Prescriber Restrictions	Infectious Disease or Pulmonologist
Coverage Duration	24 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sivextro (tedizolid)

Products Affected

- Sivextro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation member has an infection caused by or strongly suspected to be caused by a type of pathogen and site of infection within the FDA label or compendia supported -AND- 2. Prescriber attests that they have reviewed the member's medication profile and the member is not concurrently taking any of the following: A) monoamine oxidase (MAO) inhibitor (e.g., phenelzine, isocarboxazid), B) selective serotonin reuptake inhibitor (SSRI), C) selective norepinephrine reuptake inhibitor (SNRI) OR the member will discontinue the concurrent interacting medication and be monitored. -AND- 3. Documentation of inadequate treatment response, intolerance, contraindication or nonsusceptibility to a first-line antibiotic treatment: [acute bacterial skin and skin structure infections (e.g. linezolid, vancomycin, TMP/SMX, doxycycline, nafcillin, cefazolin, clindamycin, dicloxacillin or cephalexin, penicillin)]
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) days per 180 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Solaraze

Products Affected

- Diclofenac Sodium External Gel 3 %
- Diclofenac Sodium Transdermal Gel 3 %

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of osteoarthritis, pain
Required Medical Information	Documented diagnosis of actinic keratosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	90 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Somavert (pegvisomant)

Products Affected

- Somavert

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of acromegaly. The member has had an inadequate response to surgery, radiotherapy, or a dopamine agonist (e.g., cabergoline, bromocriptine), or Somavert, through shared clinical decision making, is documented to be the best first-line option.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year.
Other Criteria	Continuation criteria: Documentation of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sprycel (dasatinib)

Products Affected

- Dasatinib

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Stelara (ustekinumab)

Products Affected

- Ustekinumab Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis (PsO): Documented diagnosis moderate to severe PsO. The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, or Hadlima. Psoriatic Arthritis PsA: Documented diagnosis of active PsA. The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, Hadlima, or Xeljanz. Crohns Disease CD: Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. Inadequate response to Amjevita or Hadlima. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	Continuation: Documentation of beneficial response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Stivarga (regorafenib)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Strensiq (asfotase alfa)

Products Affected

- Strensiq Subcutaneous Solution 40 MG/ML, 80 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	Adult-onset hypophosphatasia
Required Medical Information	Documented diagnosis of perinatal/infantile onset or juvenile-onset hypophosphatasia (HPP) confirmed by all of the following: a)Patient is less than or equal to 18 at age of onset of disease, b)Radiographic evidence of HPP, c)Rachitic deformities, d)premature loss of primary teeth prior to age 5, e)Delay in skeletal growth resulting in delay of motor development, f)History or presence of non-traumatic fractures or delayed fracture healing. Molecular genetic testing and results for mutation(s) in the ALPL gene. Baseline serum alkaline phosphatase (ALP), below normal range for patients age. Serum vitamin B-6 levels, elevated and the patient has not received vitamin B6 supplementation in the previous week. Elevated serum or urine Phosphoethanolamine (PEA) level. Baseline ophthalmologic exam and renal ultrasound being monitored for signs and symptoms of ectopic calcifications.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, an endocrinologist, geneticist or a metabolic specialist.
Coverage Duration	6 months
Other Criteria	Continuation criteria: Documentation that the patient is tolerating treatment and responding to treatment, as evidenced by improvement in respiratory status, or radiographic findings. Dose is not to exceed FDA label maximum. Strensiq can be injected three times per week or six times per week. Strensiq is only covered as a three times per week injection.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

Subvenite

Products Affected

- Subvenite Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient is unable to swallow tablets or chewable tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sutent (sunitinib)

Products Affected

- SUNItinib Malate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sylatron (peginterferon alfa-2b)

Products Affected

- Sylatron Subcutaneous Kit 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Symdeko (ivacaftor / tezacaftor)

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	6 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Synarel (nafarelin acetate)

Products Affected

- Synarel

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Endometriosis: Documented contraindication, intolerance, or treatment failure with Lupron Depot (leuprolide).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tabloid (thioguanine)

Products Affected

- Tabloid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tabrecta (capmatinib)

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tadalafil

Products Affected

- Tadalafil Oral Tablet 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Erectile Dysfunction
Required Medical Information	Diagnosis of benign prostatic hyperplasia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tafinlar (dabrafenib)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tagrisso (osimertinib)

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Takhzyro (lanadelumab-flyo)

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	Not to be used in combination with other prophylactics (Cinryze or Haegarda)
Required Medical Information	A diagnosis of hereditary angioedema (HAE) has been clinically established by or in consultation with an Allergist or Immunologist.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Talzenna (talazoparib)

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tarceva (erlotinib)

Products Affected

- Erlotinib HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FFor non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Targretin (bexarotene)

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tarpeyo (budesonide)

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Tasigna (nilotinib)

Products Affected

- Nilotinib D-Tartrate
- Nilotinib HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tavneos (avacopan)

Products Affected

- Tavneos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of severe active anti-neutrophil cytoplasmic autobody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]. Positive test of either anti-PR3 or anti-MPO. Used in combination with standard therapy including glucocorticoids
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	Continuation: Documented beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tazverik (tazemetostat)

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	must be at least 16 years old
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tepmetko (tepotinib)

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Testosterone injection

Products Affected

- Testosterone Cypionate Intramuscular Solution 100 MG/ML, 200 MG/ML, 200 MG/ML (1 ML)
- Testosterone Enanthate Intramuscular Solution

PA Criteria	Criteria Details
Exclusion Criteria	Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	Documentation in clinical chart notes of two low total testosterone levels (drawn on separate days) with elevated luteinizing hormone (LH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Thalomid (thalidomide)

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tibsovo (ivosidenib)

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Transderm Scop

Products Affected

- Scopolamine

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	No prior authorization required if 64 years of age or less.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tremfya (guselkumab)

Products Affected

- Tremfya One-Press Subcutaneous Solution Pen-Injector
- Tremfya Pen Subcutaneous Solution Auto-Injector 200 MG/2ML
- Tremfya Subcutaneous Solution Prefilled Syringe
- Tremfya-CD/UC Induction

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Trikafta (elexacaftor-tezacaftor-ivacaftor)

Products Affected

- Trikafta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of cystic fibrosis in clinical chart notes. The patient has at least one of the following mutations in the CFTR gene: F508del mutation, or a mutation that is responsive based on in vitro data (refer to prescribing information). No dual therapy with another CFTR potentiator is planned.
Age Restrictions	2 years and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: Documented beneficial response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Trulicity (dulaglutide)

Products Affected

- Trulicity

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Truqap (capivasertib)

Products Affected

- Truqap Oral Tablet
- Truqap Oral Tablet Therapy Pack 160 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Truseltiq (infigratinib)

Products Affected

- Truseltiq (100MG Daily Dose)
- Truseltiq (125MG Daily Dose)
- Truseltiq (50MG Daily Dose)
- Truseltiq (75MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Cateogry 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or, one of the following: a Class I, Iia, or Iib recommendation in the Thomson Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, or an Evidence Level A by Lexi-Drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tukysa (tucatinib)

Products Affected

- Tukysa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Turalio (pexidartinib)

Products Affected

- Turalio Oral Capsule 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tyenne (tocilizumab-aazg)

Products Affected

- Tyenne Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis (RA): Documented diagnosis of Moderate to severe active RA. Inadequate response to two of the following, unless contraindicated or not tolerated: Amjevita, Enbrel, Hadlima, Xeljanz. Adult patients with Giant Cell Arteritis (GCA): Documented diagnosis of GCA. Polyarticular Juvenile Idiopathic Arthritis (PJIA): Documented diagnosis of active polyarticular JIA. Systemic Juvenile Idiopathic Arthritis (SJIA): Documented diagnosis of active SJIA Cytokine Release Syndrome (CRS): Documented diagnosis of T cell-induced severe or life-threatening CRS.
Age Restrictions	RA/GCA: 18 years and older PJIA/SJIA/CRS: 2 years and older
Prescriber Restrictions	Prescribed by or in consultation with a Rheumatologist. For CRS, Prescribed by or in consultation Oncologist, Hematologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	For all diagnoses: Documented negative tuberculosis (TB) test CONTINUATION CRITERIA: Documentation of beneficial response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tykerb (lapatinib ditosylate)

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tyvaso (treprostinil)

Products Affected

- Tyvaso DPI Maintenance Kit Inhalation Powder 112 x 32MCG & 112 x64MCG, 112 x 48MCG & 112 x64MCG, 112 x 48MCG & 112 x80MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG
- Tyvaso DPI Titration Kit Inhalation Powder 16 & 32 & 48 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension: Documented Diagnosis of pulmonary arterial hypertension confirmed by right heart catheterization (except for interstitial lung disease - interstitial lung disease may be diagnosed by high resolution computed CT and pulmonary function tests). Currently on an endothelin receptor agonist - ERA (ambrisentan or bosentan) AND a phosphodiesterase-5 (PDE-5) inhibitor. Patient will continue current background therapy. Pulmonary Hypertension Associated with Interstitial Lung Disease: Documented of WHO Group 3 pulmonary hypertension in clinical chart notes. Documentation of Right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: Documented beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Uceris (budesonide tablets)

Products Affected

- Budesonide ER Oral Tablet Extended Release 24 Hour

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. The member has a diagnosis of active mild to moderate ulcerative colitis, AND 2. The member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide, or mesalamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ukoniq (umbralisib)

Products Affected

- Ukoniq

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium or there must be a Class I or IIa recommendation in the Thomson Micromedex DrugDex compendium.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ustekinumab

Products Affected

- Imuldosa Subcutaneous
- Steqeyma Subcutaneous Solution Prefilled Syringe
- Yesintek Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented Diagnosis of moderate to severe Plaque Psoriasis (PsO). The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, or Hadlima. Diagnosis of active Psoriatic Arthritis (PsA). The patient has failed to adequately respond to two of the following: Amjevita, Cosentyx, Enbrel, Hadlima, or Xeljanz. Crohns Disease (CD): Crohns Disease CD: Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	Continuation: Documentation of a positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Valchlor (mechlorethamine)

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vanflyta (quizartinib)

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Velsipity (etrasimod)

Products Affected

- Velsipity

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Moderate to Severe active Ulcerative Colitis (UC) in clinical chart notes. For induction of remission: The member has had an inadequate response to one of the following TNF blockers (infliximab or adalimumab). For maintenance of remission: The member has had an inadequate response to one TNF blocker (infliximab and adalimumab), and ustekinumab. d. Recent (within the past 6 months) Complete Blood Count (CBC) and Liver Function Tests (LFT), electrocardiogram (ECG), and ophthalmic exam.
Age Restrictions	
Prescriber Restrictions	gastroenterologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Venclexta (venetoclax)

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Verquvo (vericiguat)

Products Affected

- Verquvo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Diagnosis heart failure classified as one of the following: a. New York Heart Association Class II, III, or IV. 2. Ejection fraction is less than 45 percent. 3. One of the following: a. hospitalization for heart failure. b. outpatient IV diuretics for heart failure. 4. patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated dose of all of the following: (unless contraindicated or not tolerated): a. beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) b. angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, lisinopril), angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), or angiotensin receptor-neprilysn inhibitor (ARNI) (e.g., Entresto), c. aldosterone antagonist (e.g., spironolactone).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	One (1) year
Other Criteria	Continuation criteria: positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Verzenio (abemaciclib)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vfend (voriconazole)

Products Affected

- Voriconazole Intravenous Solution Reconstituted
- Voriconazole Oral Suspension Reconstituted
- Voriconazole Oral Tablet 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of invasive aspergillosis, candidemia, esophageal candidiasis, a disseminated (widespread) Candida infection in the skin, or a Candida infection in the abdomen, kidney, bladder wall, or wounds and a documented trial/failure of fluconazole. Documented fungal infection caused by Fusariosis or Scedosporium species. Documentation that a culture and sensitivity test was completed to confirm diagnosis in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vitrakvi (larotrectinib)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vizimpro (dacomitinib)

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vonjos (pacritinib)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voquezna (vonoprazan Triple)

Products Affected

- Voquezna Triple Pak

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.Confirmed Diagnosis of Helicobacter pylori (H. pylori) 2. Trial and failure, contraindication, or intolerance to triple therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One 14 day per 365 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voquezna (vonoprazan)

Products Affected

- Voquezna Dual Pak

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.Confirmed Diagnosis of Helicobacter pylori (H. pylori) 2. Trial and failure, contraindication, or intolerance to bismuth quadruple therapy
Age Restrictions	
Prescriber Restrictions	Gastroenterologist or a primary care provider (PCP).
Coverage Duration	one 14 day course per year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voranigo (vorasidenib)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Votrient (pazopanib)

Products Affected

- PAZOPanib HCl Oral Tablet 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vowst (fecal microbiota spores, live-bprk)

Products Affected

- Vowst

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Vraylar (cariprazine)

Products Affected

- Vraylar Oral Capsule Therapy Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.Major Depressive Disorder (MDD): Must be used as adjunctive or add on treatment for Major Depressive Disorder (MDD), not as monotherapy. AND a. The patient must have a documented trial and failure (minimum of 4 weeks) of at least one (1) drug from the following classes: SSRI, SNRI, bupropion, or mirtazapine, AND b. Trial and failure of aripiprazole or quetiapine in combination with an antidepressant for at least four (4) weeks. 2. Schizophreniia: Trial and failure of two (2) atypical antipsychotics for a minimum of four (4) weeks (non-responders) or 12 weeks (partial responders) - e.g., aripiprazole, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, first-generation antipsychotics, OR member has a current diagnosis of metabolic syndrome, pre-metabolic syndrome, or diabetes mellitus and has failed aripiprazole and ziprasidone, unless there is a documented contraindication or intolerance. 3. Bipolar: Bipolar: a. Trial and failure of two (2) alternatives from the following: i. lamotrigine, ii. lithium, iii. carbamazepine, iv. valproic acid, v. Atypical Antipsychotics (e.g., aripiprazole, lurasidone, quetiapine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vyndamax (tafamidis)

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Exclusion Criteria	Less than 18 years of age, concomitant use with patisiran or inotersen.
Required Medical Information	Documented Diagnosis of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Patient has experienced a positive clinical response (e.g. cardiac function, serum TTR levels).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vyndaqel (tafamidis meglumine)

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	Less than 18 years of age, concomitant use with patisiran or inotersen.
Required Medical Information	All of the following must be met: Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM) - AND, one of the following: documentation that the member has a pathogenic TTR mutation (e.g., V30M) - OR, cardiac or non-cardiac tissue biopsy showing histologic confirmation of ATTR amyloid deposits - OR, all of the following: echocardiogram or cardiac magnetic resonance imagining suggestive of amyloidosis - AND, radionuclide imaging (99mTc-DPD, 99mTc-HMDP) showing grade 2 or grade 3 cardiac uptake - AND, absence of light chain amyloidosis - AND, member has New York Heart Association (NYHA) Functional Class I, II, or III heart failure - AND, one of the following: history of heart failure with at least one hospitalization for heart failure - OR, presence of clinical signs and symptoms of heart failure (e.g., shortness of breath, edema).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months Renew: 1 year
Other Criteria	Renew: Patient has experienced a positive clinical response (e.g. cardiac function, serum TTR levels).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Vyvanse (lisdexamphetamine)

Products Affected

- Lisdexamfetamine Dimesylate Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Attention Deficit Hyperactivity Disorder (ADHD): a. diagonosis of ADHD. b. Patient has had an inadequate response to at least one-month trial of at least two of the following generic medications: amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methylphenidate. 2. Binge Eating Disorder (BED): a. diagnosis of BED. b. Inadequate response to a selective serotonin reuptake inhibitor (SSRI) or topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Wegovy (semaglutide)

Products Affected

- Wegovy

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Welireg (belzurifan)

Products Affected

- Welireg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Winrevair (sotatercept-csrk)

Products Affected

- Winrevair

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	a. 18 years of age or older. b. Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. c. Currently on an endothelin receptor agonist - ERA (e.g., ambrisentan or bosentan) AND sildenafil. d. Will be used in combination with current background therapies. e. Platelet count is greater than 50.f. Prescribed by or in consultation with a cardiologist or pulmonologist.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Continuation criteria: Documented beneficial response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xalkori (crizotinib)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xeljanz (tofacitinib)

Products Affected

- Tofacitinib Citrate ER
- Tofacitinib Citrate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Rheumatoid Arthritis (RA): Documented diagnosis of Moderate to severe active RA in clinical chart notes. Trial and failure or intolerance to one or more TNF blockers. 2. Psoriatic Arthritis (PsA): Documented diagnosis of active PsA in clinical chart notes. Trial and failure or intolerance to one or more TNF blockers. 3. Ankylosing Spondylitis (AS): Documented diagnosis of active AS. Trial and failure or intolerance to one or more TNF blockers. 4. Juvenile Idiopathic Arthritis (JIA): Documented diagnosis of polyarticuar JIA in clinical chart notes. Trial and failure or intolerance to one or more TNF blockers. 5. Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active UC. Trial and failure or intolerance to one or more TNF blockers.
Age Restrictions	RA/AS/UC: 18 years of age or older PsA/JIA: 2 years of age or older
Prescriber Restrictions	1. RA/JIA/AS- prescribed by or in consultation with a rheumatologist. 2. PsA- prescribed by or in consultation with a dermatologist or rheumatologist. 3. UC- prescribed by or in consultation with a gastroenterologist.
Coverage Duration	One (1) year
Other Criteria	For all diagnoses: Documented negative TB test. CONTINUATION CRITERIA: Documentation of beneficial response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xenazine (tetrabenazine)

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	Tetrabenazine is not covered for patients who are actively suicidal, who have untreated or inadequately treated depression, who have impaired hepatic function, or who are currently taking monoamine oxidase inhibitors or reserpine.
Required Medical Information	Treatment of chorea associated with Huntington's disease. Documentation that member is being monitored for depression and suicidal ideation.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Documentation of beneficial response to therapy in clinical chart notes
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xermelo (telotristat)

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes documenting ALL of the following: 1)A diagnosis of carcinoid syndrome diarrhea, 2)An inadequate treatment response to a somatostatin analog (SSA), at a maximum tolerated dose, after at least 3 months of therapy, 3)A documented trial/failure of adjunct treatment with an anti-diarrheal medication, such as loperamide or ondansetron, 4)Chart notes documenting at least four bowel movements per day, 5)Xermelo will be used by the patient in combination with a SSA.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist or Gastroenterologist
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Diagnosis of carcinoid syndrome diarrhea, and the patient will continue to use Xermelo with a SSA. Chart notes documenting a decrease in baseline in the amount of daily bowel movements.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xifaxan (rifaximin)

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Xiidra (lifitegrast)

Products Affected

- Xiidra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of dry eye disease in clinical chart notes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Renewal: Documentation of beneficial response to therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xolair (omalizumab)

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Asthma: Documented diagnosis of moderate to severe persistent asthma with a positive skin test or in vitro reactivity to a perennial aeroallergen. Documentation that symptoms are inadequately controlled with inhaled corticosteroids. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP): Documented diagnosis of CRSwNP in clinical chart notes. Request for add-on maintenance treatment for patients with inadequate response to nasal corticosteroids. IgE-Mediated Food Allergy: Documented diagnosis in clinical chart notes. To reduce allergic reactions (Type I), including anaphylaxis. Chronic Spontaneous Urticaria (CSU): Documented diagnosis in clinical chart notes. Requests for symptomatic CSU despite H1 antihistamine treatment.
Age Restrictions	Asthma 6 years of age or older, Chronic Spontaneous Urticaria 12 years of age or older, IgE-Mediated Food Allergy 1 year of age or older, Chronic rhinosinusitis 18 years of age or older
Prescriber Restrictions	Allergist, Pulmonologist, Dermatologist, Immunologist, or Otolaryngologist.
Coverage Duration	Initial: six (6) months. Renewal: one (1) year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xospata (gilteritinib)

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xpovio (selinexor)

Products Affected

- Xpovio (100 MG Once Weekly)
- Xpovio (40 MG Once Weekly)
- Xpovio (40 MG Twice Weekly)
- Xpovio (60 MG Once Weekly)
- Xpovio (60 MG Twice Weekly)
- Xpovio (80 MG Once Weekly)
- Xpovio (80 MG Twice Weekly)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Xtandi (enzalutamide)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

Xyrem (sodium oxybate)

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	Will not be approved in combination with sedative hypnotics or alcohol, or if patient has a succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Adults: If using for excessive daytime sleepiness in narcolepsy. For mild to moderate severity, trial and failure of, or intolerance to a cerebral stimulant (methylphenidate or dextroamphetamine) and Nuvigil (armodafinil). Pediatric patients will not be required to first try and fail a cerebral stimulant or armodafinil
Age Restrictions	7 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Yonsa (abiraterone)

Products Affected

- Yonsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Yulithira (everolimus)

Products Affected

- Yulithira

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zejula (niraparib)

Products Affected

- Zejula Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zelboraf (vemurafenib)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zenbexus (iberdomide)

Products Affected

- Zenbexus

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Six (6) months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zolinza (vorinostat)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zydelig (idelalisib)

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zykadia (ceritinib)

Products Affected

- Zykadia Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-FDA approved indications, there must be a Category 1 or 2A recommendation in the National Comprehensive Cancer Network (NCCN) compendium, or one of the following: a Class I, IIA, or IIB recommendation in the Micromedex DrugDex compendium, narrative text that is supportive by the AFHS-DI or Clinical Pharmacology, an Evidence Level A by Lexi-Drugs, or peer-reviewed medical literature (as defined in Chapter 15 of the Medicare Benefit Policy Manual) that has been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zymfentra (infliximab-dyyb)

Products Affected

- Zymfentra (1 Pen)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Crohn's Disease (CD) and Ulcerative Colitis (UC): Documented diagnosis of moderately to severely active CD as evidenced by colonoscopy, CT scan, MRI, or capsule endoscopy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	For all diagnoses: 1. Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy, 2. The appropriate Disease Specific Criteria has been met. CONTINUATION CRITERIA: Documentation of positive response to treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zyvox (linezolid)

Products Affected

- Linezolid Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Vancomycin-Resistant Enterococcus faecium infections, nosocomial pneumonia, Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, Uncomplicated skin and skin structure infections, or Community-acquired pneumonia in clinical chart notes. Provider must document culture and sensitivity testing was completed and pathogen is susceptible to linezolid. Documented trial and failure of one formulary antibiotic to which the isolated pathogen is susceptible per the culture and sensitivity report.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Non-VREF: 14 days VREF: 28 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

A

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Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.

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French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (TTY: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. ومتاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) (خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DİKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.

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